173-3-06.9 **Older Americans Act: case management.**

(A) "Case management" has the same meaning as in 42 U.S.C. 3002(11).

(B) Requirements for every AAA-provider agreement for case management paid, in whole or in part, with Older Americans Act funds:

(1) The AAA-provider agreement is subject to rule 173-3-06 of the Administrative Code.

(2) The case manager is responsible for providing case management to every consumer in the PSA who receives one or more of the following services if those services are paid, in whole or in part, with Older Americans Act funds:

(a) ADS under rule 173-3-06.1 of the Administrative Code.

(b) Chores under rule 173-3-06.2 of the Administrative Code.

(c) Homemaker service under rule 173-3-06.4 of the Administrative Code.

(d) Personal care under rule 173-3-06.5 of the Administrative Code.

(e) Home-delivered meals under rule 173-4-05.2 of the Administrative Code.

(3) The case manager shall do all of the following act ivies, unless exempted in paragraph (B)(4) of this rule:

(a) Conduct an in-depth assessment of each consumer or caregiver, as appropriate, using an ODA-approved assessment tool.

(b) Provide the consumer or caregiver with accurate and complete information about available services, including services that the consumer may self-direct; eligibility; and conditions of acceptance for services.

(c) Inform the consumer or caregiver of their rights and responsibilities in relation to services.

(d) Inform the consumer or caregiver of arrangements for, or access to, one-time-only or emergency services and, if arranged, document the consumer's or caregiver's name and type of service arranged.

(e) Develop a service plan for ongoing care in collaboration with the consumer or caregiver and other appropriate person chosen by the consumer to identify and record all of the following:

(i) The service(s) identified in collaboration for the consumer or caregiver.

(ii) How to provide each service.

(iii) The provider of each service.

(iv) The dates for starting and ending each service, accomplishing milestones, and assessing progress.

(v) The standards for assessing accomplishment of milestones and progress toward established goals.

(vi) The process to revise the plan as needed.

(f) Implement the service plan by doing all of the following:

(i) Authorize and record the covered services to be provided to the consumer or caregiver.

(ii) Record referrals made for non-covered services (services other than those authorized).

(iii) Give each consumer or caregiver seeking services a list of agencies that provide authorized services.

(iv) Facilitate the consumer's or caregiver's access to the provision of services and document the facilitation in the consumer's or caregiver's service plan.

(v) Assist the consumer or caregiver in obtaining needed services and resources through education and advocacy.

(vi) Provide direct intervention to assist the overall goals of the consumer's or caregiver's plan.

(g) Monitor each service plan by doing all of the following:

(i) Determine and record the type and quantity of service(s) that the consumer or caregiver received.

(ii) Identify and record the consumer's or caregiver’s progress toward established goals.

(iii) Identify and record the quality and appropriateness of the service(s) provided.

(iv) Identify, record, and reassess the service goals.

(v) Resolve any problems related to the service(s).

(vi) Refer the consumer or caregiver, upon request, to legal assistance to assist with appeals, hearings, or grievances.

(h) Monitor the plan according to paragraph (B)(3)(g) of this rule before the earliest of the following:

(i) Ninety days after the start of the plan or since the plan was last monitored.

(ii) Whenever a change occurs that affects the consumer's eligibility or need.

(i) Conduct a home visit to comply with paragraphs (B)(3)(g) and (B)(3)(h) of this rule, but no less than every six months.

(j) Conduct a home visit to redetermine the consumer's eligibility before the earliest of the following:

(i) One year after the start of the plan or since the plan was last redetermining eligibility.

(ii) Whenever a significant change occurs that may affect eligibility.

(k) End service plans by doing all of the following:

(i) Identify, assess, and record the consumer's or caregiver's progress toward their plan's goals.

(ii) Identify and record the consumer's or caregiver's status at the end of the plan.

(iii) Identify and record the reason(s) for ending the plan, including but not limited to the following:

(a) The consumer voluntarily terminates the plan.

(b) The consumer no longer requires the services.

(c) The consumer refuses the services.

(d) The consumer moves out of the PSA.

(e) The consumer expires.

(f) The consumer becomes a resident of a long-term care facility or is admitted to a hospital or institution and the consumer's stay is indefinite.

(4) The case manager is not responsible for completing the activities in paragraphs (B)(3)(g) to (B)(3)(j) for a consumer after that consumer no longer receives one or more of the services listed under paragraph (B)(2) of this rule.

(5) Benefits: The provider may help a consumer apply for benefit programs.

(6) Qualifications:

(a) No person qualifies to be a case manager unless the person meets all of the following qualifications:

(i) The person has a thorough knowledge of Older Americans Act services in the PSA.

(ii) The person has the necessary knowledge, skills, and experience to do all of the following:

(a) Assess a consumer's or caregiver's strengths and need for services.

(b) Conduct the core functions of case management.

(c) Integrate services.

(d) Work as part of a team of service providers on behalf of the consumer or caregiver.

(e) Assume responsibility for their own professional growth and continuing education to enhance their case management skills and keep up with the many changes of available resources in the health and social services fields.

(b) The provider may allow a person who is not a case manager to provide the intake activities of case management only if the person has the necessary

knowledge, skills, and experience to appropriately refer consumers to case managers.

(7) Service verification: The following are the mandatory reporting items for each episode of service that a provider retains to comply with the requirements under paragraph (B)(9) of rule 173-3-06 of the Administrative Code:

(a) Consumer's name.

(b) Date of activity.

(c) Description of activity.

(d) Units provided.

(e) Name of each employee providing the activity.

(f) The unique identifier of the employee to attest to providing the activity.

(g) The unique identifier of the consumer or the consumer's caregiver to attest to receiving the activity. During a state of emergency declared by the governor or a federal public health emergency, the provider may verify the activity provided without collecting the unique identifier of the consumer or the consumer's caregiver.

(C) Units: A unit of case management is sixty minutes. Providers may report partial hours to two decimal places (e.g., "0.25 hours").

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
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